STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004811	A. BUILDING: _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 34586 Facility Number: 004811 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey 2/2/15-2/4/15 Date of ISDH off site review - April 28, 2015 Reviewer/Surveyor --Kerry Sawin RN, PHNS Based on review of the April 4 - 6, 2015 HFAP Accreditation Survey Report, it has been determined that Central Indiana AMG Specialty Hospital meets the requirements for Hospital Licensure in Indiana for 2015.	S 000		